Missouri Vaccines for Children Program
LPHA Vaccine Transfer/Replacement Report

I. PROVIDER INFORMATION

FROM:	TO:
Provider Name	Provider Name
Address	Address
City, State, Zip	City, State, Zip
Telephone Number / PIN Number	Telephone Number / PIN Number

II. THESE VACCINES ARE BEING: ___ TRANSFERRED TO ANOTHER CLINIC
THESE VACCINES ARE BEING: ____ REPLACED FROM PRIVATE PURCHASE (Check one only)

VACCINE	# OF DOSES	LOT NUMBER	MANUFACTURER	EXP. DATE	DATE TRANSFERRED
DTaP					
DTaP/HB/IPV *(Pediarix)*					
DT (< 7 years)					
Td *(Booster)*					
Tdap					
EIPV					
Hep A					
Hep A-Adult (MOI only)					
Hep A/Hep B-18					
Hep B					
Hep B-Adult (LPHAs)					
Hep B/Hib					
Hib					
HPV					
MCV4 *(Menactra)*					
MMR					
MMRV					
Pneumo-23					
PNU-7 *(Prevnar)*					
Rotavirus					
Varicella					
FluMist					
Flu .5 ml dose					
Flu (P-Free) .25 ml dose					

III. TRANSFER AUTHORIZATIONS - Provider Contact(s)/Immunization Quality Manager as required (Replacement)

Signature of Person Transferring Vaccine:	Signature of Person Receiving Vaccine:

INSTRUCTIONS on reverse side

INSTRUCTIONS

Definitions:

Transfer Vaccine: This occurs when one provider gives VFC vaccines to another provider. (There is no cost incurred by the "transferring" or "receiving" provider.)

Replacement Vaccine: This occurs when vaccine is purchased from a private source for the purpose of replacing VFC vaccine that was negligently wasted (as determined by VFC program staff).

Transferring VFC Vaccine from One Provider to Another

Section I. **(FROM: section)** List provider information of the clinic transferring vaccine.
(TO: section) List provider information of the provider receiving the vaccine.

Section II. **Check "transferred"** and complete the required information listed in each column for all vaccines being transferred.

Section III. **Person transferring** vaccine signs where indicated **(left side).**
Person receiving vaccine signs where indicated **(right side).**

Replacement of VFC Vaccine from Privately Purchased Source

Section I. Complete your provider information in **first column only**.

Section II. **Check "replaced"** and complete the required information listed in each column for all vaccines being replaced.

Section III. **Provider contact person** signs in the "transferring" section **(left side).**
Immunization Quality Manager validates the replacement by signing in the receiving vaccine column **(right side).**

Contact the VFC Program (800-219-3224) or your Immunization Quality Manager when your private purchase replacement vaccine arrives (within 60 days of receipt of your replacement letter) to schedule an appointment to validate the replacement transaction.

REMEMBER

Record the information from this transfer/replacement report on your monthly accountability sheet.

If **"Replacing or Receiving"** vaccine list the number of doses received for each vaccine on **line 2, Vaccine Received** column of your monthly accountability form.

If **"Transferring"** vaccine to another clinic list the number of doses transferred for each vaccine on **line 3, Vaccine Transferred Out** column of your monthly accountability form.

Fax the Vaccine Transfer/Replacement Report with your VFC monthly accountability to **(573) 526-5220**.